acromegaly being present, and that symptoms directly referable to this body may be wanting in gigantism, make him conclude that the general belief is untenable. There are many arguments which favor the view that acromegaly is not caused by pituitary tumor. While there may be a certain relationship between the rapidity of growth of the latter and the amount of thickening in the bones, this is by no means constant. Granted that this disorder does not depend on a specific internal secretion, a cause for the hypophyseal hypertrophy must be sought. It is a well-known fact that poisons in the circulation, such as arsenic, alcohol, lead, etc., can cause changes in the peripheral parts of the body. There are also diseases dependent upon the production within the body in some unknown way of toxin which can lead to vasomotor and trophic disturbances in the same sites. Raynaud's disease has been considered as such. It is probable that, due to heredity, constitution, diet, etc., toxins may be produced which have a selective action on certain tissues. Thus arthritis deformans and hypertrophic pulmonary arthropathy involve the bones; chemical poisons, diphtheria, etc., the nerves; scleroderma and myxedema, the skin, etc. Acromegaly also begins in the periphery, and at its outset there may be symptoms of Raynaud's disease; it thus seems likely that leucomains are the essential cause. The analogy is further borne out by the cerebral symptoms which suggest a toxemia. But where do these toxins come from? Most, no doubt, would say the hypophysis, but for this Boettiger thinks there is no proof

The case described was put on vegetable diet and treated with iodine, hydrotherapy, peripheral faradization and central galvanization with the most encouraging results. JELLIFFE.

93 "UEBER DIE BEZIEHUNGEN DER AKROMEGALIE ZUM DIABETES MELLITUS" (On the Relation of Acromegaly to Diabetes Mellitus). Schlesinger. (Weiner klinische Rundschau, 1900, No. 15).

According to the author, diabetes may occur in acromegalic patients in two forms, the one differing little from diabetes in other persons, pursuing a regular course and unless modified by diet, and treatment, the quantity of sugar excreted remaining quite constant. In the other form, the quantity of urine and the percentage of sugar may undergo sudden variations independent of treatment or diet, the sugar sometimes disappearing entirely for a time, or being present only when large quantities of starches or sugar have been ingested. The first class of cases he would make dependent upon increase of connective tissue in the pancreas, in connection with the same process elsewhere. For the second, he would make the growth of the hypophysis, and the thereby increased cerebral pressure, responsible. Three cases whose clinical histories he gives would seem to support these views, but there are no autopsy findings given, as the patients are still living. ALLEN.

94 "A CASE OF CEREBRAL ABSCESS WITH OPERATION." Leutert (Vereins-Beilage, No. 20 der Deutschen med. Wochenschrift, No. 21, 1900). In the Verein für wissenschaftliche Heilkunde in Königsberg i. Pr.

Leutert presented a patient who had had pain in the back of the neck, and right-sided headache. The pupils reacted promptly, and no paresis, no disturbance of sensation and no ankle clonus were observed. He had chronic purulent otitis media. The area about the ear was normal in appearance and not painful on pressure. Temperature was 36.1-36-2. No optic neuritis was detected, but there was some impairment of the mental functions. A history of nausea, vomiting and constipation, lasting several months, was obtained. On the second day after the first examination, coma with loss of the corneal reflex developed, and then left-sided paresis was detected. At least 200 c.cm. of pus were obtained from the right temporal lobe by trephining. After six weeks the patient was discharged much improved. SPILLER.

95 "DIE CORRELATIVE EMPFINDLICHKEITS-SCHWANKUNG" (The Correlative Variation of Sensibility). Strausky and Ten Cate. (Wiener klin. Rundschau, 1900, XIV, 15, S. 290).

The authors put to themselves the following questions: 1. Does the production of *hypoesthesia* in one skin area produce *hyperesthesia* in another region?

2. If it does, is it in a symmetrically situated area and in what relation do the respective areas stand to each other?

3. Is this relationship such that homology with the so-called "transfer" is conceivable?

4. What are the conditions in pathological cases?

The results obtained in the examination of 40 cases, half healthy, half having nervous diseases, are utilized. Local anesthesia was produced by ethyl chloride, by Scheich's solution, and by ice. The hair esthesiometer of von Frey was used. Their conclusions are as follows:

1. In healthy persons without sensory disturbance, production of local hypoesthesia gives rise to *hyperesthesia* for touch and pain, in other skin areas, both on the same and on the opposite side. This they designate "correlative variation of sensibility," and speak of its "projection."

2. This variation is most marked in those areas, whether on the same or on the opposite side, which are supplied from the same *spinal* segment.

3. In skin regions supplied from neighboring segments, some variation may occur, but it is much less marked, and in areas supplied from distant segments there is little or no variation even though they may be located nearly symmetrically with regard to the hypoesthetic area.

4. With the manifestations of "transfer" correlative variation of sensibility has nothing to do. The former seems to be of cortical origin.

5. On account of insufficient number of observations and lack of autopsies, the authors do not feel justified in drawing positive conclusions with regard to cases having already some sensory defect, but simply state what they found.

a. In 4 cases of segmental involvement of the cord, "projection" either *from* or *to* the skin supplied from the diseased segment, was impossible. Where the lesion involved the whole cross section, the areas supplied from the segments below this showed no projection. Where only the gray matter was involved the segmental areas, both above and below, reacted normally.

b. In 6 cases of neuritis, projection was impossible *from* or *to* the skin supplied by the affected nerve.

c. In 3 cases of functional hemihypoesthesia projection *to* the affected area was impossible, but was observed *from* it.

d. In 1 case of cerebral syphilis (meningitis) projection occurred as in a normal person.

e. In 2 cases of Basedow's disease no projection to the face, but in other parts of the body it occurred normally. ALLEN.